



2023 Medicare Regulatory Update: IPPS Final Rule

September 22, 2022

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Presenters



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Agenda



01 MS-DRGS	05 MEDICARE DSH & UC PAYMENTS
02 PAYMENT RATES	06 SECTION 1115 WAIVERS
03 GME	O7 OTHER PAYMENT AND REGULATORY ITEMS FOR CONSIDERATION
04 WAGE INDEX	08 REIMBURSEMENT RELATED ITEMS



Medicare Severity Diagnosis Related Groups (MS-DRGs)



MS-DRGs

- ➤ No new MS-DRGs for 2023, list is set at 767.
- ➤ CMS finalized a permanent 10% cap on decreases in an MS-DRG's relative weight from one fiscal year to the next. Many comments were submitted regarding the size, duration and implementation of this proposal CMS elected to finalize its proposal.
- Further delays implementation of the "three-way split criteria" because of the magnitude of the impact during the ongoing Public Health Emergency (PHE).
- CMS is returning to use FY 2021 Medicare Provider Analysis and Review (MedPAR) claims data and FY 2020 cost report data for FFY 2023 Medicare payment rate setting.



Annual Recalibration

- > DRG weights re-calibrated on annual basis using claims data and cost report data:
 - FY 2021 MedPAR claims and the FY 2020 cost reports, for the FY 2023 rate.
 - With certain modifications for the anticipated decline in COVID-19 hospitalizations of Medicare beneficiaries.
- Modify the calculation of the FY 2023 MS-DRG relative weights:
 - First calculating two sets of weights, one including and one excluding COVID-19 claims.
 - Modify methodologies for determining the FY 2023 outlier fixed-loss amount.
- ➤ Implement a permanent 10-percent cap on the reduction in any individual MS-DRG's relative weight in a given fiscal year.



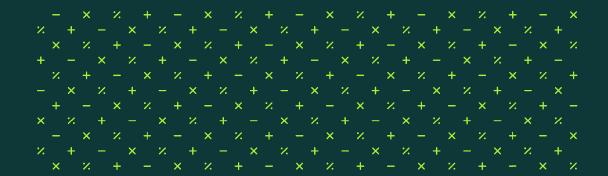
New Technology Add-On Payments (NTAP)

- ➤ The NTAP program provides for additional payment to hospitals for cases involving eligible new and relatively high-cost technologies utilized during inpatient hospital stays.
- ➤ CMS approved eight technologies that applied for new technology add-on payments for FY 2023, while also conditionally approving one technology and finalizing approval on another technology from 2022.
- > CMS is continuing 15 previously approved technologies.
- ➤ That's a total of 25 eligible for payment in 2023 for approximately \$784 million in spending.



Payment Rates





CMS FY 2023 Final Rule Percentage Change – Inpatient Payments

- ➤ IPPS operating payment rates will increase by 4.3 percent in FY 2023 relative to FY 2022 for acute care hospitals that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful electronic health record (EHR) users. This increase is the result of a 4.1 percent market basket update less a 0.3 percent multi factor productivity adjustment plus a legislative adjustment of 0.5 percent.
- > Overall payments to acute care hospitals are expected to increase by \$2.6 billion in FY 2023 as a result of the 4.3 percent increase less impact of the increase in the outlier threshold, HOWEVER:
- Projected payment decreases include:
 - \$300 million in Disproportionate Share Hospital (DSH)/Uncompensated (UC) payments.
 - \$750 million in new technologies.
 - \$600 million for Medicare-Dependent, Small Rural Hospitals (MDH) and low-volume hospitals.



DRG Payment Rates (Quality Data/Meaningful Use et) Wage Index > 1.0000

	FFY 2023 Final	FFY 2022 Final CN
Labor-Related	\$4,310.00	\$4,138.24
Non-Labor	2,065.74	1,963.41
Capital	483.76	472.59
Total Payment Rate	\$6,859.50	\$6,574.24

Wage Index <= 1.0000

	FFY 2023 Final	FFY 2022 Final CN
Labor-Related	\$3,952.96	\$3,795.42
Non-Labor	2,422.78	2,326.23
Capital	483.76	472.59
Total Payment Rate	\$6,859.50	\$6,594.24



Labor/Non-Labor DRG Rates: Wage Index > 1.0000

Description (for FFY 2023-Final for 10/01/22)	Labor	Non-Labor
FY2023 Base Rate, after removing PY Reduction Factors	\$4,431.41	\$2,123.93
FY2023 Net Market Basket Update Factor - SEE NEXT SLIDE	1.038	1.038
FY2023 MS-DRG Recalibration Budget Neutrality Factor (BNF)	1.000509	1.000509
FY 2023 Cap Policy MS-DRG Weight Budget Neutrality Factor	0.999764	0.999764
FY2023 Wage Index Budget Neutrality Factor (BNF)	1.000968	1.000968
FY2023 Reclassification 'BNF'	0.984399	0.984399
FY2023 Lowest Quartile 'BNF'	0.998146	0.998146
FY 2023 Cap Policy Wage Index Budget Neutrality Factor	0.999689	0.999689
FY2023 Operating Outlier Factor	0.949000	0.949000
FY2023 Rural Demonstration Budget Neutrality Factor	0.998935	0.998935
FY2023 Sections 414 (MACRA) and 15005 of PL 114-255 (+.50%)	1.005	1.005
National Standardized Amount FY2023 DRG Payment Rate	\$4,310.00	\$2,065.74

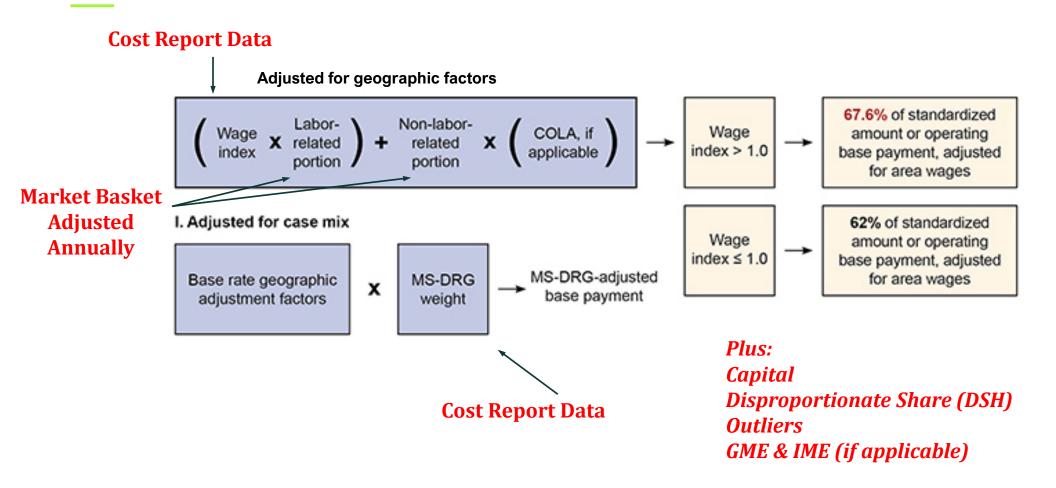


FFY 2023 Update

	Quality Data Submitted and Meaningful User	Quality Data Submitted / NOT a Meaningful User	Quality Data NOT Submitted / Meets Meaningful Use	Quality Data NOT Submitted / NOT a Meaningful User
Market Basket (MB) "Rate of Increase"	4.1%	4.1%	4.1%	4.1%
Failure to submit Quality Data	0.00	0.00	-1.025	-1.025
Failure to meet Meaningful Use	0.00	-3.075	0.00	-3.075
Multifactor Productivity (MFP) Adjustment	-0.3	-0.3	-0.3	-0.3
Net Percent Increase/Decrease	3.8%	0.725%	2.775%	-0.3%



IPPS Payment Methodology





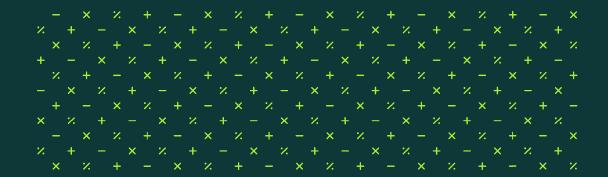
Outliers: Fixed Loss Threshold

- Modify the methodology for calculating payments on outlier cases within the IPPS to account for data uniquely impacted by COVID-19 by averaging:
 - 2021 data including COVID cases and payment increases.
 - 2021 data excluding COVID cases.
- Proposed outlier threshold for FFY 2023 is \$43,214.
- Final outlier threshold for FFY 2023 is \$38,859.
- > FFY 2022 final outlier threshold is \$30,988.
- Represents a 25% increase.



Graduate Medical Education (GME)





Graduate Medical Education

- Adopted proposal without significant modification effective for cost reporting periods beginning on or after October 1, 2001.
 - Adjusted to make the total weighted FTE count equal the FTE cap.
- ➤ Permit GME affiliation agreements for urban and rural teaching hospitals that train residents in a rural track program.
- ➤ CMS will cap the pool of funds available for Nursing and Allied Health (NAH) Medicare Advantage payments for calendar years (CYs) 2020 and 2021 at the \$60 million cap imposed by the Balanced Budget Refinement Act (BBRA) of 1999.
- > CMS will reduce Medicare Advantage GME payments to hospitals by 3.71% for CY 2020 and 3.22% for CY 2021 to fund the NAH Medicare Advantage payment pool.



Medicare Wage Index Update



Current Use of Medicare Area Wage Index (AWI) Data (Refresher)

The "adjusted"* area wage index is currently used in:

- Medicare inpatient prospective payment system (IPPS)
- Medicare outpatient prospective payment system (OPPS)
- California Medi-Cal FFS (APR-DRG) system**

The "unadjusted" *** area wage index is used in:

- Medicare skilled-nursing facility PPS
- Medicare inpatient rehabilitation facility PPS
- Medicare inpatient psychiatric facility PPS
- Other Medicare payment systems (ESRD, HHA, Hospice, others)

Many hospitals factor the "adjusted" AWI into Medicare Advantage (MA) and Medi-Cal Managed Care contracts in their rate-setting process.



^{*} The "adjusted" AWI accounts for geographic reclassifications, rural floor budget neutrality and occupational (occ) mix.

^{**}Any change to Medi-Cal FFS in one year will be adjusted the following year to make the change budget neutral.

^{***} The "unadjusted" AWI excludes occupational (occ) mix survey adjustments

FY 2023 Continuation of Low Wage Index Hospital Policy

- > CMS elects to continue its low wage index hospital policy that it first adopted in FY 2020.
 - Bridgeport Hospital v. Becerra, No. 20-cv-1574, 2022 WL 612658 (D.D.C. Mar. 2, 2022), in which the Court on March 2, 2022, found the agency did not have the statutory authority to adopt this policy.
- Under this policy, CMS makes upward adjustments to the wage indices of hospitals with a wage index value below the 25th percentile.
- The adjustment for each eligible hospital is equal to half of the difference between the otherwise applicable final wage index value for the hospital and the 25th percentile wage index value for all hospitals that same year.
- For FY 2023, CMS identified the 25th percentile wage index to be 0.8427.
- As in past years, CMS is proposing to fund these adjustments by making a budget neutrality adjustment to the standardized amount. The proposed budget neutrality adjustment is 0.998146.



Hold Harmless Permanent

- Began in FY 2020 as a transition policy.
- Extended in FY 2021 and 2022.
- > Permanent 5% cap on all wage index decreases each year, regardless of the circumstances.
- Budget-neutral manner by reducing the standardized amount.



Proposal – Reclassifications

- > Revises the regulations governing urban hospitals with multiple campuses seeking to reclassify as rural.
- Amend its regulation to provide that rural reclassification under 42 C.F.R. § 412.103 applies only to the main campus and any remote locations located in an urban area, and not remote locations in rural areas.



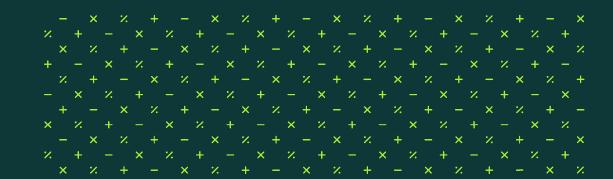
Wage Index Values

- > CMS is to use the FY 2019 data for the FY 2023 wage index.
- The method used to compute the proposed FY 2023 wage index without an occupational mix adjustment follows the same methodology that was used to compute the wage indexes without an occupational mix adjustment in the FY 2021 IPPS/LTCH PPS final rule.
- ➤ Use of 2019 Medicare Wage Index Occupational Mix Survey for the FY 2023 wage index.
- ➤ Rural floor calculation returning to pre-FY2020 methodology
- Estimate that 275 hospitals would receive an increase in their FY 2023 wage index due to the application of the rural floor.
- > Imputed floor will be applied for FY 2023.



Medicare Disproportionate Share Hospital (DSH)/Uncompensated Care (UC)





Uncompensated Care – Final Rule Factor 1

➤ Baseline FY 2019 - \$13.814 billion (PY \$13.882 billion)

FY	Update	Discharge	Case Mix	Other	Total	DSH	2022 Rule
2020	1.031	0.862	1.038	0.9952	0.9181	12.682	12.801
2021	1.029	0.939	1.029	1.0174	1.0116	12.829	13.267
2022	1.025	0.986	0.990	1.0235	1.0241	13.138	13.985
2023	1.043	1.050	0.990	0.9793	1.0618	13.949	

Update column is determined as follows:

FY	MB	ACA cut	Prod	D&C	Total
2020	3.0	0	-0.4	0.5	3.1
2021	2.4	0	0	0.5	2.9
2022	2.7	0	-0.7	0.5	2.5
2023	4.1	0	-0.3	0.5	4.3



Uncompensated Care – Factor 1 Trends

FFY	DSH Estimate	25% Empirically Justified DSH	Factor 1
2014	\$12,790,922,790	\$3,197,730,698	\$9,593,192,093
2015	\$13,383,462,196	\$3,345,865,549	\$10,037,596,647
2016	\$13,411,096,528	\$3,352,774,132	\$10,058,322,396
2017	\$14,396,635,710	\$3,599,158,928	\$10,797,476,783
2018	\$15,552,939,524	\$3,888,234,881	\$11,664,704,643
2019	\$16,339,055,838	\$4,084,763,960	\$12,254,291,879
2020	\$16,583,455,657	\$4,145,863,914	\$12,437,591,743
2021	\$15,170,673,476	\$3,792,668,369	\$11,378,005,107
2022	\$13,984,752,729	\$3,496,188,182	\$10,488,564,547
2023	\$13,948,974,706	\$3,487,243,677	\$10,461,731,029



Uncompensated Care – Final Factor 2

CY 2022 uninsured: 8.9%

CY 2023 uninsured: 9.3%

FY 2023 weighted uninsured: $(8.9\% \times .25) + (9.3\% \times .75) = 9.2\%$

2013 uninsured: 14%

1-|((9.2% - 14%) / 14%| = 1-34.29% = 65.71% (68.57% 2022 Final Rule)



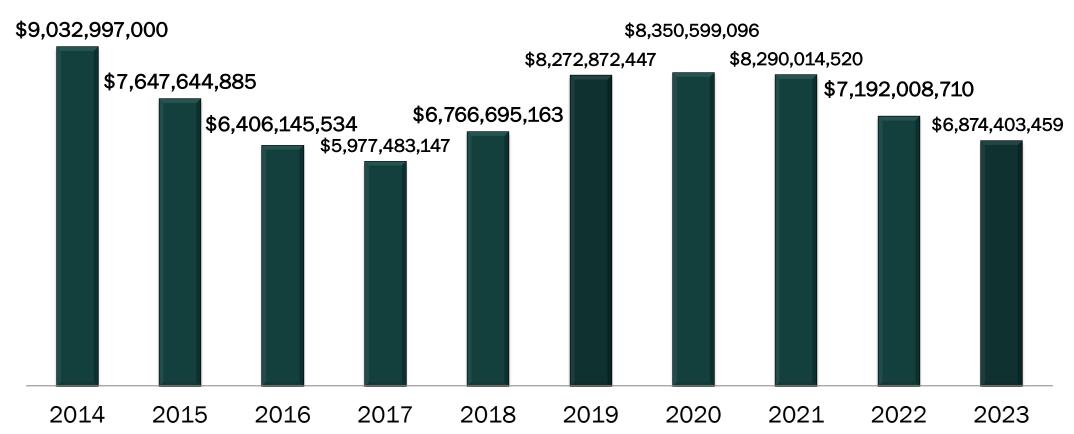
Uncompensated Care – Final UC Pool Total

- ➤ 2023 Gross Pool from Factor 1 = \$10.462 billion (\$9.949B Proposed Rule)
- > 2023 Final Factor 2 = 65.71% (unchanged from Proposed Rule) \$10.462 * 65.71% = \$6.874 Billion

- ➤ 2023 Final Uncompensated Care Amount = \$6.874 billion (6.537B-Proposed Rule)
 - Distributed to 2,380 hospitals
 - Decrease of \$318 Million (4.4%) from 2022 final rule



UC Pool Trends





Uncompensated Care – Factor 3

- > FFY 2018 & FFY 2019 Line 30 S-10 data to derive Factor 3 for FY 2023:
 - Using the average of the audited FY 2018 and audited FY 2019 reports.
 - Addresses concerns from stakeholders regarding year-to-year fluctuations in UC payments.

> Future S-10 Use:

- For FY 2024 and subsequent years to use a three-year average of UC data from the three most recent audited fiscal years.
- Specifically for FY 2024, CMS expects to use data from FY 2018, FY 2019, and FY 2020.



FFY 2018 & 2019 S-10 Cost Report Comparison – 2021 HCRIS Q2 vs. 2022 Q1 results

Change in Line 30 UC

FFY	Providers	Change	Percent
2018	2,208	\$(1,439,170,956)	-4.46%
2019	2,165	\$(1,852,298,458)	-5.53%
TX - 2019	179	\$(100,955,931)	-1.57%

- 2,165 Providers out of 2,380 revised their 2019 cost report during June 2021 March 2022
- 5.53% decrease in Line 30 for those 2,165 Providers



FFY 2018 & 2019 S-10 Cost Report Comparison – 2021 HCRIS Q2 vs. 2022 Q1 Results (cont'd)

Charity Care Changes Line 20

				Unins	ured	Insur	ed	Tot	al
FFY	Providers	No Change	Revised	Change	Percent	Change	Percent	Change	Percent
2018	2,208	217	1,991	\$625,477,123	.73%	\$(1,270,360,563)	-24.36%	\$(644,883,440)	71%
2019	2,165	201	1,964	\$687,116,240	.72%	\$(1,533,327,661)	-29.66%	\$(846,211,421)	82%
TX – 2019	179	26	153	\$86,934,466	3.72%	\$(24,771,417)	-4.97%	\$62,163,049	.229%

- 1.3 Billion dollar decrease in insured charity charges
- Insured charity not subject to the cost to charge ratio
- Dollar for dollar impact on Line 30 total



FFY 2018 & 2019 S-10 Cost Report Comparison – 2021 HCRIS Q2 vs. 2022 Q1 Results (cont'd)

Bad Debt Line 26

FFY	Providers	No Change	Revised	Change	Percent
2018	2,208	186	2,022	\$(2,764,330,592)	-6.48%
2019	2,165	269	1,896	\$(1,734,635,356)	-4.34%
TX – 2019	179	48	131	\$(181,812,827)	-3.67%

- \$1.7 billion decrease
- Bad debt was reviewed by MACs in the 2019 S-10 audits
- Non-Medicare bad debt not reviewed by hospitals as thoroughly as Medicare bad debt



FFY 2018 & 2019 S-10 Cost Report Comparison – 2021 HCRIS Q2 vs. 2022 Q1 Results Summary

FFY	Average/Min/Max	Change
2018	Avg Line 30 Change	\$(651,798)
2018	Largest Line 30 Decrease	\$(159,787,481)
2018	Largest Line 30 Increase	\$47,426,702
FFY	Average/Min/Max	Change
2019	Average of Line 30 Change	\$(855,565)
2019	Largest Line 30 Decrease	\$(304,527,296)



Next Steps and Best Practices – Uncompensated Care

- ➤ MACs are currently performing Worksheet S-10 audits on <u>all</u> FFY 2020 cost reports:
 - Designate an individual(s) and budget S-10 preparation and audit support time for each fiscal year.
 - Deep dive into your transaction codes and business practices to ensure Worksheet
 S-10 is capturing all of the hospital's uncompensated care.
 - Consider revising S-10 data as necessary and amend for FFY 2021.

> Filing Requirements:

- Worksheet S-10 Charity Care patient detail required at time of cost report filing (10/1/18 and after). Detail must be +/- 3% of cost report values.
- Additional requirements and revised templates including total bad debt on horizon?



Medicare DSH Update – Dual Eligible Decision

> Background:

- Health and Human Services (HHS) issued a rule in 2004 that stated if a patient met the basic criteria (eligible) for Medicare they should be included in the Medicare fraction of the DSH calculation.
- Empire Health challenged the calculation and argued the rule violates the Medicare statue and HHS did not follow correct procedures when the regulation was crafted.
- Ninth Circuit Court of Appeals voided the rule and sided with Empire.
- Case was appealed to the Supreme Court who heard oral arguments last fall.

> Becerra v. Empire Health Foundation

- Supreme Court issued decision on June 24, 2022.
- Ruled 5-4 that the HHS followed correct procedures when it drafted a 2004 rule on the calculation of DSH payments to safety net hospitals.
- Supreme Court found Empire's interpretation "fits poorly with the statutory structure."
- Justice Elena Kagan wrote that Empire's interpretation of the statute could have a patient going back and forth between Medicare and Medicaid fraction based on the happenstance of the actual Medicare payments.
- Kavanaugh argued in dissent that HHS changed the process in 2004 "presumably to save money."

Proposed Revisions to Form CMS-2552-10

- > CMS published a notice in the Federal Register dated June 22, 2022.
- ➤ Medicare DSH, Worksheet S-10, and Medicare bad debt updates:
 - New Medicare DSH template required at cost report filing.
 - New Worksheet S-10 instructions. Current S-10 designated as "Part I" with revised instructions. New Part II section carving out only general short term hospital inpatient and outpatient services billable under the hospital CCN.
 - New charity and total bad debt templates similar (but different) to the current audit templates.
 - New Medicare bad debt template.



- Exhibit 3A Listing of Medicaid eligible days for Medicare DSH eligible hospitals.
- Required for cost reporting periods beginning on or after October 1, 2022.
- Patient-level detail is required for each category of days reported on lines 24 and 25, columns 1 through 6.

EXHIBIT 3A

FORM CMS-2552-10

TITLE	MEDICAID ELIGIBLE DAYS FOR A DSH ELIGIBLE HOSPITAL
PROVIDER NAME	
CCN	
CRP BEGINNING DATE	
CRP ENDING DATE	
WS S-2, PT. I, LINE #	
PREPARED BY	
DATE PREPARED	
TOTAL COLUMNS 10 &12	
TOTAL COLUMN 11	

		PATIENT CLAIM	INFORMATION				
PATIENT LAST NAME	PATIENT FIRST NAME	DATE OF SERVICE - FROM	DATE OF SERVICE - TO	PATIENT ACCOUNT NUMBER	MEDICAL RECORD NUMBER	MEDICAID NUMBER	STATE ELIGIBILITY CODE
1	2	3	4	5	6	7	8

		MEDICA	IID DAYS							
	WKST S-2,				INSURANCE OR		ME	<i>DICARE ELIGIBII</i>	LITY	
	PARTI		LABOR &		OTHER PA	YER NAME				
	COLUMN	ELIGIBLE	DELIVERY	NEWBORN			A/B			
	NUMBER	DAYS	ROOM DAYS	BABY DAYS	PRIMARY	SECONDARY	INDICATOR	START DATE	END DATE	COMMENTS
]	9	10	11	12	13	14	15	16	17	18

40-38.4 Rev.

2022 Medicare Cost Report Exhibits

- Exhibit 2A Listing of Medicare Bad Debts.
- Required for cost reporting periods beginning on or after October 1, 2022.
- Separate Exhibit 2A should be submitted for each provider number in the health care complex and separated by inpatient and outpatient.
- Distinguish between dually eligible crossover accounts and non-dually eligible accounts.

4004.2 (Cont.) FORM CMS-2552-10 DRAFT

EXHIBIT 2A

TITLE	MEDICARE BAD DEBTS
PROVIDER NAME	
CCN	
SUBPROVIDER CCN	
CRP BEGINNING DATE	
CRP ENDING DATE	
INPATIENT / OUTPATIENT	
PREPARED BY	
DATE PREPARED	
TOTAL COLUMN 24	
TOTAL DUAL ELIGIBLE	

PATIENT NAME LAST	PATIENT NAME FIRST	DATE OF SERVICE: FROM	DATE OF SERVICE: TO	PATIENT ACCOUNT NUMBER	MBI OR HICN 6	MEDI- CAID NUMBER 7	DEEMED INDI- GENT 8	MEDI- CARE REMIT- TANCE ADVICE DATE	MEDI- CAID REMIT- TANCE ADVICE DATE 10	SEC- ONDARY PAYER RA RE- CEIVED DATE	BENE- FICIARY RESPON- SIBILITY AMOUNT	DATE FIRST BILL SENT TO BENE
	-		,			,						- 10

A/R WRITE OFF DATE	SENT TO COLLEC- TION AGENCY (Y/N) 15A	RETURN FROM COLLEC- TION AGENCY DATE 15	COLLEC- TION EFFORT CEASED DATE 16	MEDI- CARE WRITE OFF DATE 17	RECOVER- IES ONLY: AMOUNT RECEIVED 18	RECOVER- IES ONLY: MCR FYE DATE 19	MEDI- CARE DE- DUCTIBLE AMOUNT* 20	MEDI- CARE CO- INSUR- ANCE AMOUNT*	CURRENT YEAR PAY- MENTS RECEIVED AMOUNT 22	CURRENT YEAR PAY- MENTS RECEIVED SOURCE 23	ALLOW- ABLE BAD DEBTS AMOUNT 24	COM- MENTS 25

^{*} Report deductible and coinsurance amounts only when the provider billed the patient with the expectation of payment. See column 8 instructions for possible exception.

40-52 Rev.

2022 Medicare Cost Report Exhibits

- Exhibit 3B Listing of charity care amounts.
- Required for cost reporting periods beginning on or after October 1, 2022.

<u>DRAFT</u> FORM CMS-2552-10 4012.2 (Cont.)

EXHIBIT 3B

TITLE	CHARITY CARE CHARGES
PROVIDER NAME	
HOSPITAL CCN	
COMPONENT CCN	
CRP BEGINNING DATE	
CRP ENDING DATE	
PREPARED BY	
DATE PREPARED	
UNINSURED COLUMN 20	
INSURED COLUMN 20	

	PATIEN	T CLAIM INFOR	MATION					TOTAL	PHYSICIAN /	DEDUCT- IBLE /
PATIENT NAME - LAST	PATIENT NAME - FIRST	DATE OF SERVICE - FROM	DATE OF SERVICE - TO	PATIENT ACCOUNT NUMBER	INSURANCE STATUS	PRIMARY PAYOR	SECONDARY PAYOR	CHARGES FOR CLAIM	PROFES- SIONAL CHARGES	COINSUR / COPAY AMOUNTS
1	2	3	4	5	6	7	8	9	10	11

TOTAL THIRD PARTY PAYMENTS 12	INSURED CONTRAC- TUAL ALLOWANCE AMOUNT 13	NON- COVERED CHARGES 14	TOTAL PATIENT PAYMENTS 15	AMOUNTS WRITTEN OFF AS BAD DEBT 16	UNINSURED DISCOUNT AMOUNTS 17	CHARITY CARE NON- COVERED CHARGES 18	OTHER CHARITY CARE CHARGES 19	AMOUNTS WRITTEN OFF TO CHARITY CARE AND UNINSURED DISCOUNTS 20	WRITE OFF DATE 21

Rev. 40-80.9

FORM CMS-2552-10 DRAFT

2022 Medicare Cost Report Exhibits

4012.2 (Cont.)

- Exhibit 3C Listing of total bad debt.
- Required for cost reporting periods beginning on or after October 1, 2022.

EXHIBIT 3C

TITLE	TOTAL BAD DEBTS
PROVIDER NAME	
HOSPITAL CCN	
COMPONENT CCN	
CRP BEGINNING DATE	
CRP ENDING DATE	
PREPARED BY	
DATE PREPARED	
TOTAL COLUMN 17	

	PATII	ENT CLAIM INFORMA	4TION				
PATIENT LAST NAME	PATIENT FIRST NAME	DATE OF SERVICE - FROM	DATE OF SERVICE - TO	PATIENT ACCT NUMBER	INSURANCE STATUS	PRIMARY PAYOR	SECONDARY PAYOR
1	2	3	4	5	6	7	8

INI	ERVICE DICATOR IP / OP) 9	TOTAL CHARGES 10	TOTAL PHYS- ICIAN / PROFES- SIONAL CHGS	TOTAL PATIENT PAYMENTS 12	TOTAL THIRD PARTY PAYMENTS 13	PATIENT CHARITY CARE AMOUNT 14	CONTRACTUAL ALLOWANCE / OTHER AMOUNT 15	A/R WRITE OFF DATE 16	PATIENT BAD DEBT WRITE OFF AMOUNT 17

40-80.12 Rev.

Section 1115 Waivers



Section 1115 Waivers – Recent History

- > Recent court decisions to include days in DSH calculation:
 - Bethesda Health Inc. v. Azar
 - Forest General Hospital v. Azar
 - Health Alliance Hospitals Inc. v. Azar
- ➤ 2022 Proposed Rule:
 - CMS proposed to include only days in which a patient directly receives inpatient hospital insurance coverage from a Section 1115 waiver.
 - Would have excluded days where hospitals receive payment from an uncompensated care pool.
 - Would have excluded days for patients who receive premium assistance through a section 1115 demonstration.
 - CMS did not finalize proposal and planned to revisit issue in future rulemaking.



Section 1115 Waivers – 2023 Rule

2023 Proposed Rule:

• Revise regulations to explicitly reflect interpretation of the language "regarded as" "eligible for medical assistance under a State plan approved under title XIX" to mean patients who receive health insurance through a section 1115 demonstration itself or purchase such insurance with the use of premium assistance provided by section 1115 demonstration.

For the groups CMS "regard" as Medicaid eligible, CMS proposed:

- Only days of those individuals that obtain health insurance that provides essential health benefits (EHB).
- Or with premium assistance that provides EHB where premium assistance is equal to or greater than 90% of the cost of the health insurance.

> CMS again chose not to finalize the proposed rule

CMS expects to revisit the issue of section 1115 demonstration days in future rulemaking.



Other Payment and Regulatory Items for Consideration



Rural Emergency Hospitals

- New designation
- > ER and other outpatient services only. No Inpatient
- > REH services paid at 105% of OPPS
- > REHs will receive a monthly facility payment
- ➤ Enrollment available starting January 2023



Performance and Data Reporting Items

- CMS will resume certain Hospital Readmissions Reduction Program data use.
- ➤ Finalized various changes including suppressing the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and five Hospital Acquired Infection (HAI) measures for the FY 2023 Program year due to the lingering impacts of COVID-19.
- Finalized scoring and payment methodology for Hospital Acquired Conditions (HAC) for the FY 2023 program year by suppressing certain measures.
- Adoption 10 new measures for the Hospital Inpatient Quality Reporting (IQR) Program.



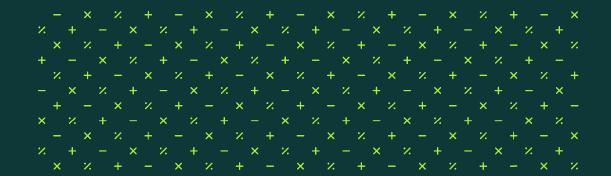
Other Items

- ➤ Proposes revising the hospital and Critical Access Hospital (CAH) infection prevention and control Conditions of Participation (CoP) requirements to continue COVID-19 and seasonal flu reporting requirements.
 - CMS estimates that the proposed changes would result in additional annual cost of \$38,204,400 for weekly reporting and \$536,331,000 for daily reporting.
- ➤ Requests comments on the appropriateness of an IPPS and Outpatient Prospective Payment System payment adjustment for N95 respirators.



Reimbursement Related Items





FY 2023 Outlook and Beyond

Trustees Report to Congress June 2, 2022

Table II.B1.—Medicare Data for Calendar Year 2021					
		SMI			
	HI or Part A	Part B	Part D	Total	
Assets at end of 2020 (billions)	\$134.1	\$133.3	\$10.0	\$277.4	
Total income	\$337.4	\$435.5	\$114.6	\$887.6	
Pay roll taxes Interest Taxation of benefits Premiums General revenue Transf ers from States Other	302.5 2.6 25.0 4.2 1.4 —	2.7 — 111.0 318.6 — 3.3	0.1 17.0 85.3 12.1 0.3	302.5 5.3 25.0 132.1 405.4 12.1 5.3	
Total expenditures	\$328.9	\$405.5	\$104.9	\$839.3	
Benefits Hospital Skilled nursing facility Home health care Phy sician fee schedule services Priv ate health plans (Part C) Prescription drugs Other ¹	323.6 144.8 28.4 6.2 — 147.7 — -3.5	400.5 64.5 — 10.8 73.8 202.2 — 49.2	104.4 — — — — — 104.4	828.5 209.3 28.4 17.0 73.8 349.9 104.4 45.7	
Administrative expenses	5.3	5.0	0.5	10.8	
Net change in assets	\$8.5	\$30.1	\$9.7	\$48.3	
Assets at end of 2021 Enrollment (millions)	\$142.7	\$163.3	\$19.7	\$325.7	
Aged Disabled Total	55.1 8.3 63.4	50.8 7.6 58.4	43.2 6.8 49.9	55.5 8.3 63.8	
Av erage benefit per enrollee ¹	\$5,105	\$6,860	\$2,091	\$14,056	

Madiagra Data for Calandar Vacr 2024

Note: Totals do not necessarily equal the sums of rounded components.

Table II D4



¹Includes net repayments of \$29.1 billion and \$19.0 billion to Part A and Part B, respectively, for the Medicare Accelerated and Advance Payments Program.

FY 2023 Outlook and Beyond

Trustees Report to Congress June 2, 2022

Table II.B1.—Medicare Data for Calendar Year 2021					
			SMI		
	HI or Part A	Part B	Part D	Total	
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Madiana Data for Calandar Vacu 2004

Note: Totals do not necessarily equal the sums of rounded components.



¹Includes net repayments of \$29.1 billion and \$19.0 billion to Part A and Part B, respectively, for the Medicare Accelerated and Advance Payments Program.

HI Financial Outlook

Table II.E1.—Estimated Operations of the HI Trust Fund under Intermediate Assumptions, Calendar Years 2021–2031

[Dollar amounts in billions]

FY 2023 Outlook	-
and Beyond	

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Calendar y ear	Total income ¹	Total expenditures	Change in fund	Fund at y ear end	Ratio of assets to expenditures ²
2021 ³	\$337.4	\$328.9 ⁴	\$8.5	\$142.7	41%
2022	386.0	356.2 ⁴	29.8	172.4	40
2023	412.6	415.6	-3.0	169.4	41
2024	430.2	444.6	-14.3	155.1	38
2025	450.5	476.7	-26.2	128.9	33
2026	475.1	510.7	-35.6	93.3	25
2027	500.4	545.4	-45.0	48.3	17
2028 ⁵	523.7	580.6	-56.9	-8.6	6
2029⁵	547.9	616.6	-68.7	-77.3	6
2030 ⁵	570.4	650.5	-80.1	-157.4	6
2031 ⁵	593.7	683.7	-90.0	-247.4	6

¹Includes interest income.

Note: Totals do not necessarily equal the sums of rounded components.



²Ratio of assets in the fund at the beginning of the year to expenditures during the year.

³Figures for 2021 represent actual experience.

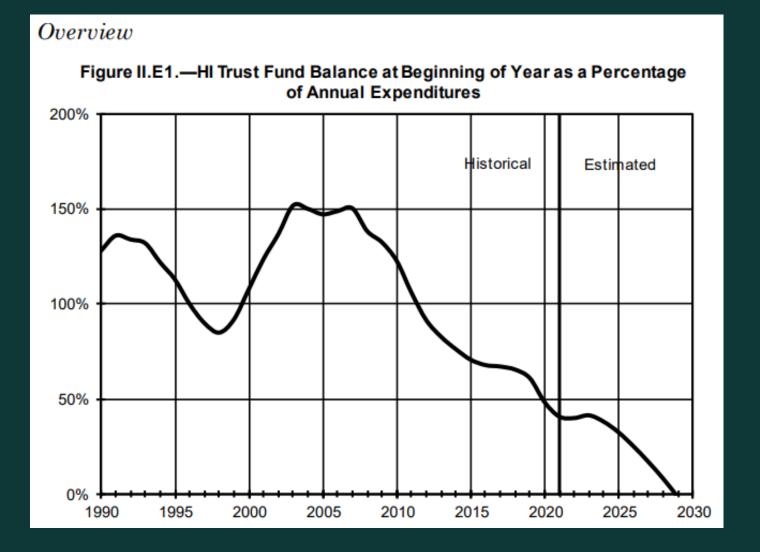
⁴Includes net repayments of \$29.1 billion and \$34.4 billion in calendar years 2021 and 2022, respectively, for the Medicare Accelerated and Advance Payments Program.

⁵Estimates for 2028 and later are hypothetical since the HI trust fund would be depleted in those years.

⁶Trust fund reserves would be depleted at the beginning of this year.

FY 2023 Outlook and Beyond

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FY 2023 Outlook and Beyond

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Overview

Table II.D1.—Components of Increase in Medicare Incurred Expenditures by Part

				percentj			
_			Av erage	annual percer	ntage change		
		Prices		_			
_		Medicare		_	Beneficiary		
Valuation		relativ e to	Ov erall	Number of	demographic	Volume and	Total
period	CPI	CPI	Medicare	beneficiaries		intensity	increase
Part A:							
2022-2031	2.6%	-0.3%	2.2%	2.1%	-0.3%	2.5%	6.7%
2032-2046	2.4	0.1	2.5	0.6	0.4	1.4	4.9
2047-2096	2.4	-0.2	2.2	0.5	-0.1	1.3	3.9
Part B:							
2022–2031	2.6	-1.1	1.5	2.2	0.0	4.5	8.4
2032-2046	2.4	-0.2	2.2	0.6	0.1	2.6	5.7
2047-2096	2.4	-0.2	2.2	0.5	-0.1	1.5	4.2
Part D:							
2022–2031	2.6	-0.4	2.2	2.5	-0.2	1.5	6.1
2032-2046	2.4	0.4	2.8	0.6	-0.1	1.5	4.9
2047–2096	2.4	0.4	2.8	0.5	-0.1	1.4	4.7

Notes: 1. Price reflects annual updates, total factor productivity reductions, and any other reductions required by law or regulation.

- Volume and intensity is the residual after the other four factors shown in the table (CPI, excess Medicare price, number of beneficiaries, and beneficiary demographic mix) are removed.
- 3. Totals do not necessarily equal the sums of rounded components.



MedPAC Testimony

- > 2021 Congressional Budget Office (CBO) estimated annual Medicare spending will double in the next 10 years between 2021 and 2031 (to \$1.8 trillion).
- Making up 18.8% of total federal spending in 2031.
- > Insolvency:
 - CBO estimated by 2027
 - Trustee by 2026
- Remedy:
 - Increase in payroll tax from 2.9% to 3.7%, or
 - Reduce Part A spending immediately by 19% (estimated \$70 billion in 2022).



MedPAC Testimony (cont.)

- > Payment rates for post-acute care sector are <u>Unnecessarily High</u>
 - Skilled Nursing Facilities (eliminate annual increase, roll back current rates 5%).
 - Home Health Agencies (eliminate annual increase, roll back current rates 5%).
 - Inpatient Rehabilitation Facilities (eliminate annual increase, roll back current rates 5%).
 - Hospices (eliminate annual increase, reduce cap on payments 20%).
 - Combined impact of these proposals equals \$25 billion to \$40 billion savings over fiveyears.

➤ Medicare Advantage:

- Annual enrollment increasing 10% per year.
- 46% of eligible Medicare beneficiaries enrolled in MA plans.
- Payment rates (in 2022) estimated to equal 104% what FFS would have spent for the same beneficiaries.



MedPAC Testimony (cont.)

- Medicare Advantage What Medpac is telling Congress:
 - Coding differences between FFS and MA plans, higher payments to MA plans.
 - Quality reporting no longer provides accurate description of the quality of care in MA plans.

Conclusion:

- Medicare spending is expected to more than double over the next decade.
- Spending will continue to strain solvency of the trust funds.

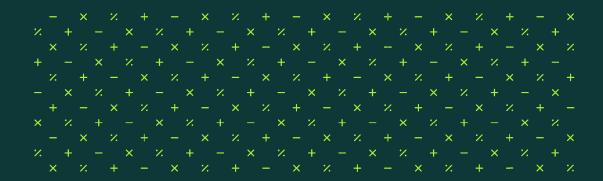


Recent AHA Advocacy

- Continued support for stressed and strained workforce:
 - No additional funding for delta and omicron surges.
 - Distribute the remaining funds in the PRF.
 - Add \$25 billion new funds to help with variant surges.
 - Extend sequester relief to later of end of PHE or 12/31/22.
 - Extend repayment window for accelerated and advance payments.
 - Retain 340B eligibility if DSH % falls during 2020 and 2021.
 - Staffing shortages and "travel" nurse costs additional relief needed.



Next Steps, Closing Thoughts & Questions



Resources

- > DSH/UC impacts analysis (by request)
- > Subscribe
- ➤ Health Care Content Hub <u>www.mossadams.com/industries/health-care/insights</u>
- > Events & Webcasts <u>www.mossadams.com/events</u>
- ➤ <u>Annual Health Care Conference</u> Nov. 3-4th, Las Vegas



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Augment in-house resources or fully outsource an enterprise-wide solution. Our professionals can handle all aspects of your reimbursement needs that will support your overall strategy and the operations of your health care organization.

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Cost Report Preparation, Analysis, & Audit Support	Medicare DSH Reporting & Audit Support	State Reporting Requirements
Cost Report Appeals, Filing, & Management	Month End Close Support	Volume Decrease Adjustment
Home Office Cost Allocations & Reporting	Outsourcing & Staff Augmentation	Wage Index Preparation & Reviews
Medical Education Program Implementation, Expansion, & Reviews	Regulatory Analysis & Interpretation	Worksheet S-10: Charity Care & Bad Debt & Audit Support



Reimbursement Enterprise-wide Solutions

ADDITIONAL EXPERTISE

340B Program-Related Services	Expense Controls & Performance Improvement	Medicaid Matching	Revenue Cycle Processes
AR Valuations	Formulate Third-Party Reserves for Financial Reporting Purposes	Net Patient Revenue Analysis & Calculations	Roll Forward Analysis
Charge Master Standardization & Maintenance	Geographic Reclassifications	Organ Acquisition & Transplant Programs	Service Line Impact Analysis
Cliff Impact Analysis	Government Payment Programs Training	Outlier Reconciliations	State Provider Tax Programs
Clinical Pathway Reviews for Inpatient & Outpatient Service Lines	Government Programs Profitability Analysis	Payment Rate Reviews & Third-Party Payment Variance Analysis	Strategic Business Planning
Contractual Model Reviews for Compliance & Accuracy	Ground Ambulance Data Collection	Provider-based & Outpatient Service Line Assessments	Succession Planning
Due Diligence	Medicaid DSH reviews	Rate Setting & Application of Overhead Rates	



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Provider-based Licensure & Certification

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Uncompensated Care / Bad Debt

Medicare DSH Analysis & Appeals

Worksheet S-10

Wage Index Reviews

Outsourced Reimbursement & Staff Augmentation

STRATEGY & INTEGRATION

Provider Risk Analysis, Contracting & Operational Design

M&A Support

Feasibility Studies

Market Intelligence & Benchmarking

Service Line Enhancement & Analysis

Strategic Planning & Implementation

Managed Care Assessment & Negotiation

GOVERNMENT COMPLIANCE

Regulatory Compliance

Coding Validation

Coding Department Redesign

EHR Internal Controls

Corporate Compliance

LEAN TRANSFORMATION

3P & Innovation: redesign processes, products, facilities

Lean Management Systems and Strategy Deployment

Lean operations

Quality & patient safety

PRVIATE EQUITY

Investment Evaluation & Transactions

Advising Portfolio Companies

Selling Portfolio Companies

OPERATIONAL IMPROVEMENT

Revenue Cycle Enhancement

Claims Audits & Recovery

Litigation Support

Employer Health Benefits

Financial Turnaround

Performance Excellence

Operational Assessments & Process Improvement

INFORMATION TECHNOLOGY

HIPAA Security and Privacy

Network Security & Penetration Testing

HITRUST Assessment & Certification

SOC Pre-Audit Gap Analysis & Readiness

SOC Audits

Disaster Recovery Planning



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Shawn Coughlin The National Association for Behavioral Health (NABH)



Susan Dentzer America's Physician Group



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Andy Davidson
Gallagher Executive
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- How Health Care Leaders are Strategizing for the Future
- Weathering the Financial Storm & Emerging a Stronger, Sustainable Health Care Organization: Strategy, Operations & Reimbursement Opportunities
- We're still talking about Moving from Volume to Value: The Future of Risk-Sharing and Value-Based Care Post Pandemic
- Medicare Advantage: The Future of Health Care, or the Canary in the Coal Mine?
- Addressing the urgency for behavioral health integration across the care continuum
- Hospital at Home: Where is it at and where is it going?
- The RX for Transformation with Dr. Phil Polakoff
- Keynote with Dr. Anupam Jena, Physician, Economist, and Co-Host of *Freakanomics*, *M.D.* podcast
- Why We Need A Recovery Plan for America's Physicians, Dr. Resneck, President of AMA
- Raising Capital
- Workforce in Crisis: Retaining and Recruitment Strategies for Health Care
- [Webcast] Keynote session with CMS administrators
- [Webcast] Politics & the Pandemic

